Missouri Department of
SOCIAL SERVICES
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MATT BLUNT, GOVERNOR • DEBORAH E. SCOTT, DIRECTOR

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December 9, 2008

The Honorable Matt Blunt
Governor of the State of Missouri
State Capitol Building, Room 216
Jefferson City, Missouri 65101

Dear Governor Blunt:

Section 191.909.2 of the Revised Statutes of Missouri requires the Department of Social Services to report on MO HealthNet waste, fraud and abuse. The enclosed Program Integrity Report covers state fiscal year 2008. For context, cost avoidance and recovery data for 2004 through 2008 are provided.

Please feel free to contact me if you would like to discuss.

Sincerely,

Deborah E. Scott
Director

Enclosure

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December 9, 2008

The Honorable Rod Jetton
Speaker of the House
Missouri House of Representatives
201 West Capitol Avenue
Jefferson City, Missouri 65102

Dear Speaker Jetton:

Section 191.909.2 of the Revised Statutes of Missouri requires the Department of Social Services to report on MO HealthNet waste, fraud and abuse. The enclosed Program Integrity Report covers state fiscal year 2008. For context, cost avoidance and recovery data for 2004 through 2008 are provided.

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December 9, 2008

The Honorable Michael R. Gibbons
President Pro Tem
Missouri Senate
State Capitol, Room 326
Jefferson City, Missouri 65101

Dear Senator Gibbons:

Section 191.909.2 of the Revised Statutes of Missouri requires the Department of Social Services to report on MO HealthNet waste, fraud and abuse. The enclosed Program Integrity Report covers state fiscal year 2008. For context, cost avoidance and recovery data for 2004 through 2008 are provided.

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Sincerely,

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Missouri Department of Social Services

MO HealthNet Division

Program Integrity Report

State Fiscal Year 2008

January 2009

INTRODUCTION

Senate Bill No. 577 passed by the 94th General Assembly in 2007 mandates as part of Section 191.909.2 RSMo (Cum. Supp. 2007) that the Department of Social Services report to the General Assembly and the Governor the results of provider and participant fraud reviews each year. This report covers state fiscal year 2008.

The Department of Social Services, MO HealthNet Division (MHD) is responsible for conducting provider and participant reviews to determine compliance with MO HealthNet program policy and regulations. The Program Integrity (PI) Unit within the MHD performs this function.

Case reviews of MHD providers that result in suspicion of healthcare fraud (relating to allegations of violations under sections 191.900 – 191.910) are referred to the Office of Attorney General (AGO), Medicaid Fraud Control Unit (MFCU). Case reviews of MHD participants that result in suspicion of healthcare fraud are referred to the Department of Social Services, Division of Legal Services (DLS). This report includes data available to the Department of Social Services. The Attorney General's Office will report on the performance of the Medicaid fraud responsibilities assigned to it under the law.

MO HEALTHNET PROGRAM INTEGRITY PROCESS OVERVIEW

Minimizing fraud, waste and abuse and assuring the integrity of the MO HealthNet Program requires a variety of complex methods and cooperation across agency lines. The methods focus on a continuum of concerns from prosecution of criminal fraud to ensuring that the state pays no more than its fair share of the cost to care for MO HealthNet participants. Generally speaking,

- **Waste** is defined as the expenditures of healthcare funds carelessly or needlessly and the unintentional misuse of funds through inadvertent errors.

- **Abuse** is defined as incidents or practices inconsistent with sound medical or business procedures.

- **Fraud** is defined as an intentional deception or misrepresentation that results in an unauthorized benefit or payment. Fraud can be perpetrated by service providers and by participants.

By law, MO HealthNet is the payer of last resort. This means that any medical cost incurred on behalf of a MO HealthNet participant is recoverable (or billable) to any other payer that may have responsibility for the participant's health care costs (private insurance policies, Medicare, etc.) or from other resources that may be available to the participant for his or her medical needs (settlement payments and court awards, workers' compensation, estate, etc.). The MHD Cost Recovery Unit is responsible for recovering the cost of health care from other payers. This unit works with the Attorney General's Financial Services Division to file legal claims against participants' funds in estate and tort cases. The MHD Cost Recovery Unit is also responsible for the Health Insurance Premium Payment (HIPP) Program through which MHD will pay for private insurance coverage for MO HealthNet participants when it is cost effective for the state to do so.

The MHD Program Integrity Unit is responsible for monitoring all aspects of MO HealthNet program compliance. This unit conducts post payment reviews, provider audits and uses automated systems that are programmed to detect suspicious billing and service utilization patterns. When provider or participants are found to be misusing or abusing MO HealthNet benefits, the MHD Program Integrity Unit has the authority to pursue administrative sanctions against providers and "lock-in" participants to specific providers. The MHD Program Integrity Unit initiates administrative recovery of the cost of any benefits wrongfully claimed.

When the MHD Program Integrity Unit discovers fraudulent activities, referrals are made to the Department of Social Services' Division of Legal Services (DLS) or to the Attorney General's Medicaid Fraud Control Unit (MFCU). The DLS is responsible for investigating and referring cases for prosecution of fraud perpetrated against MO HealthNet to local prosecutors. The Attorney General's MFCU is responsible for investigating and prosecuting fraud perpetrated by MO HealthNet providers and can either work with local prosecutors or pursue prosecution itself.

The following table categorizes claims as appropriate, wasteful, abusive, or fraudulent and summarizes the parties and processes for appropriate remedy.

Table 1. Summary of MO HealthNet Program Integrity Responsibilities

	- - - Continuum of MO HealthNet Claims - - -			
	Appropriate	**Wasteful**	**Abusive**	**Fraudulent**
Nature of Claim	*Medically necessary*	*Unnecessary expenditure of state funds*	*Unsound medical or business practice*	*Intentional wrongdoing*
Responsible Party	*MHD Clinical Services*	*MHD Cost Recovery* *MHD Program Integrity*	*MHD Program Integrity*	*DSS Legal Services* *AGO Medicaid Fraud Control Unit*
Processes/ Tools	*MMIS, CCIP, prior authorization/Smart PA, CyberAccess, managed care, etc.*	*TPL identification, estate and tort recovery, compliance reviews*	*Compliance reviews, automated expenditure surveillance of service utilization*	*Accept MHD referrals, investigation, prosecution*

Key to acronyms:

AGO	*Attorney General's Office*
CCIP	*Chronic Care Improvement Program*
CyberAccess	*CyberAccess Web-based tool providing health care providers with access to patient data*
DSS	*Department of Social Services*
MHD	*MO HealthNet Division*
MMIS	*Medicaid Management Information System*
Smart PA	*Web based decision rules engine for prior authorization*
TPL	*Third Party Liability*

SECTION 191.909 REPORTING REQUIREMENTS

The following section of this report lists each reporting requirement in bold followed by the MO HealthNet Division's response.

Section 191.909.2 (1)
The number of MO HealthNet provider and participant investigations and audits related to allegations of violations under sections 191.900 to 191.910 completed within the reporting year, including the age and type of cases

The Department of Social Services, Division of Legal Services (DLS) conducts investigations into suspicion of participant health care fraud. DLS investigated 326 participant cases during state fiscal year 2008.

The Office of Attorney General, Medicaid Fraud Control Unit is responsible for investigations relating to allegations of violations under Section 191.900-191.910 RSMo (Cum. Supp. 2007) and will report its performance separately.

Section 191.909.2 (2)
The number of MO HealthNet long-term care facility reviews

Long-term care facility reviews involve program integrity staff reviewing claims submitted by the long-term care provider to determine if the on-site records and charts support the services billed to the MO HealthNet Division (MHD). During 2008, the MHD Program Integrity Unit conducted 24 long-term care facility reviews, of which 14 were identified through claims analysis. The remaining 10 reviews were the result of a referral or provider self-disclosure.

The MHD Program Integrity Unit assessed and collected an overpayment in 19 of the 24 case reviews, resulting in a total recovery of $84,422. The two largest overpayments were for $40,856 and $19,685, respectively. Of the remaining cases, the recovery for

one case was previously included in another project, and no errors were identified in the four other case reviews.

The MHD Institutional Reimbursement Unit (IRU) conducts additional fiscal auditing of long-term care facilities' cost reports to ensure accuracy of nursing facility cost reporting. While the number fluctuates slightly, there are approximately 500 nursing facilities participating in MO HealthNet at any given time. IRU conducts audits on a cycle. In 2008, IRU completed 168 audits.

Section 191.909.2 (3)
The number of MO HealthNet provider and participant utilization reviews

The MHD Program Integrity Unit conducted a total of 1,823 reviews of MO HealthNet providers and participants during state fiscal year 2008. Of the 1,823 reviews completed, 269 were provider reviews, 68 were special projects, and 1,486 were participant reviews. The 337 provider reviews and special projects encompassed 4,653 providers (the number of providers reviewed through special projects may include duplicates). Please see Table 2 for data related to outcomes and amounts collected.

Section 191.909.2 (4)
The number of referrals sent by the department to the attorney general's office

The MHD Program Integrity Unit referred 25 providers with suspicion of health care fraud to the Office of Attorney General's Medicaid Fraud Control Unit during state fiscal year 2008. The MHD Program Integrity Unit referred 64 participants with suspicion of health care fraud to the Department of Social Services, Division of Legal Services during state fiscal year 2008. Please see Table 2 for the data on investigations conducted and concluded during state fiscal year 2008.

Section 191.909.2 (5)

The total amount of overpayments identified as the result of completed investigations, reviews, or audits

Table 2 summarizes overpayments and collection opportunities identified by the MHD's Cost Recovery and Program Integrity Units and by the Department of Social Services' Division of Legal Services for state fiscal year 2008.

Section 191.909.2 (6)

The amount of fines and restitutions ordered to be reimbursed, with a delineation between amounts the provider has been ordered to repay, including whether or not such repayment will be completed in a lump sum payment or installment payments, and any adjustments or deductions ordered to future provider payments

The MHD Program Integrity Unit does not have the authority to order fines or restitution. The MHD Program Integrity Unit establishes the overpayment and requests repayment from the provider in accordance with the state regulation, 13 CSR 70-3.030(6). If the provider fails to issue a check within the time allotted or establish a repayment plan, the amount is recovered by the MHD from the future claims submitted by the provider.

Section 191.909.2 (7)

The total amount of monetary recovery as the result of completed investigation, reviews or audits

The Department of Social Services' MO HealthNet Division and Division of Legal Services collections and costs avoided for state fiscal year 2008 are summarized in Table 2. These figures include the results of third party liability collections by the MHD Cost Recovery Unit. The Office of Attorney General, Medicaid Fraud Control Unit will separately report on its collection performance.

The increase in third party liability cash collections during state fiscal year 2006 is attributable to a concerted effort to prepare for the implementation of the Medicare Part D program and ensure Medicare eligibility data was timely entered into the claims payment system. This project resulted in a one-time increase in cash collections and an on-going increase in cost avoidance savings. During the following state fiscal years, as the Medicare Part D Program became primary payer on pharmacy claims of dual eligible participants, the claims subject to recovery from other third parties reduced cash collections but increased Medicare cost avoidance savings. At the same time, MHD expanded its cost avoidance editing to include pharmacy claims resulting in an additional decrease in cash collections but an increase in cost avoidance savings. As a result of recent court cases involving estate and workers' compensation recoveries, third party liability cash collections were negatively impacted in SFY 2008.

Table 2. MO HealthNet Investigations and Cost Recovery 2004 – 2008

DSS MO HealthNet Program Integrity and Cost Recovery (provider focused)			
Fiscal Year	**Cost Avoidance**	**Cost Recovery**	**Total**
2004	$ 84,708,463	$ 38,035,986	$122,744,449
2005	$ 90,904,620	$ 41,084,920	$131,989,540
2006	$123,377,373	$ 63,289,433	$186,666,806
2007	$142,884,088	$ 54,060,109	$196,944,197
2008	$162,255,546	$ 47,689,870	$209,945,416
DSS MO HealthNet/Welfare Investigation Unit (participant focused)			
Fiscal Year	**Number of Investigations**	**Cost Recovery**	**Total**
2004	249	$ 993,669	$ 993,669
2005	241	$ 1,880,286	$ 1,880,286
2006	282	$ 2,129,369	$ 2,129,369
2007	280	$ 2,088,342	$ 2,088,342
2008	326	$ 2,853,376	$ 2,853,376
DSS Reinvestigations Savings (one time)			
Fiscal Year	**Cost Avoidance**	**Cost Recovery**	**Total**
2005	$ 67,500,000	$0	$ 67,500,000
2006	$108,100,000	$0	$108,100,000
Grand Totals			
Fiscal Year	**Cost Avoidance**	**Cost Recovery**	**Total**
2004	$ 84,708,463	$ 39,029,655	$123,738,118
2005	$158,404,620	$ 42,965,206	$201,369,826*
2006	$231,477,373	$ 65,418,802	$296,896,175*
2007	$142,884,088	$ 56,148,451	$199,032,539
2008	$162,255,546	$ 50,543,246	$212,798,792

** Includes one-time cost avoidance savings due to increasing the ratio of eligibility reinvestigations to 100% over the 05-06 fiscal years.*

Section 191.909.2 (8)

The number of administrative sanctions against MO HealthNet providers, including the number of providers excluded from the program

For state fiscal year 2008, administrative sanctions were imposed against MO HealthNet providers in 254 of the 269 provider reviews. The sanctions imposed resulted in 57 providers being excluded from the program. The following are examples of regulatory sanctions as found in 13 CSR 70-3.030(4):

- Termination from participation,
- Suspension of participation,
- Suspension or withholding of payments to provider,
- Referral to peer review committees,
- Recoupment from future provider payments,
- Transfer to a closed-end agreement,
- Attendance at provider education sessions,
- Prior authorization of services,
- 100% prepayment review,
- Referral to state licensing board,
- Referral to appropriate federal or state legal agency,
- Retroactive denial of payments, and
- Denial of payment for any new admission to a SNF, ICF, or ICF/MR.